Student Diet Modification Request Form
Barbers Hill ISD School Nutrition Department

Note: Accommodations will only be made if there is a documented life-threatening food allergy or disability and will not be made until all documentation has been returned and approved.

Please complete all information required below.

A. STUDENT INFORMATION

Student Last Name: _____ Student First Name: _____

Campus: _____ Date of Birth: _____

Grade: _____ Student ID: _____

Reason for Diet Modification Request: _____

B. PARENT/LEGAL GUARDIAN CONTACT INFORMATION

Last Name: _____ First Name: _____

Phone Number: _____ Email: _____

C. DIET MODIFCATION REQUEST

Will student be eating breakfast and/or lunch at school?

☐ **YES** – Student will be eating breakfast and/or lunch at school. If yes, please complete Section D and E.

Please select all that apply: ☐ Breakfast ☐ Lunch

☐ **NO** – Student will not be eating breakfast and lunch at school. All food eaten by student will be supplied by parent/legal guardian.

D. PHYSICIAN INFORMATION

Physician Name: _____ Phone Number: _____

Clinic/Facility Name: _____ Fax Number: _____

Address: _____ City, State, Zip: _____

E. PARENT CONSENT

I, _____ (parent/guardian), authorize the above-named physician to release health and dietary information regarding the above-named student to Barbers Hill Independent School District's School Nutrition Department.

Parent/Guardian Signature: _____ Date: _____

F. RETURN COMPLETED FORM TO

Dietician/Menu Planner
Sarah Strickland
sarah.strickland@bhisd.net
(281) 576-2221, ext. 1461

Director of School Nutrition
Adeena Henning
adeena.hening@bhisd.net
(281)576-2221, ext. 1258